

CONFIDENTIAL CLIENT INFORMATION

Welcome to Water Lily. In order to make your session as enjoyable and comfortable as possible, we would appreciate it if you would take a moment to fill out this questionnaire regarding your personal health. Thank you.

NAME: _____ HM PHONE: _____ WK PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

OCCUPATION: _____ REFERRED BY: _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY BEFORE? YES NO

TYPE OF MASSAGE EXPERIENCED: DEEP TISSUE SWEDISH OTHER: _____

ARE YOU TAKING MEDICATION? YES NO PLEASE DESCRIBE: _____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

ARE YOU PREGNANT? YES NO

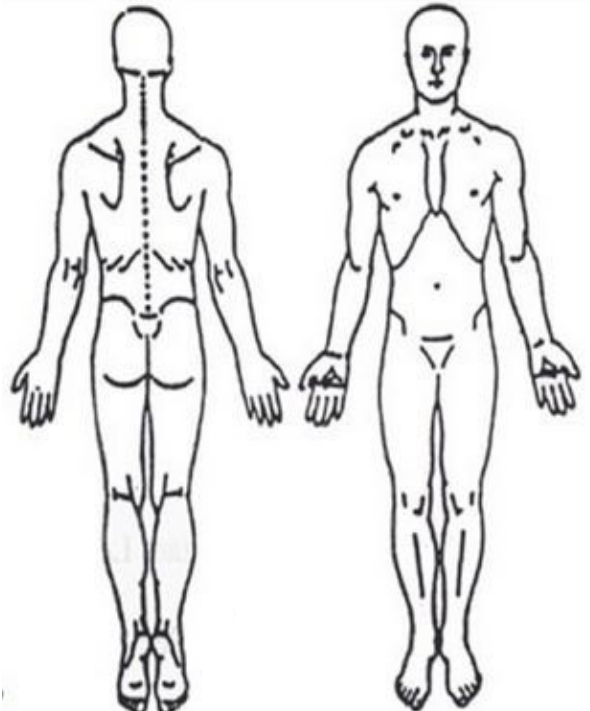
DO YOU HAVE A HISTORY OF THE FOLLOWING?

- | | | |
|---|--|--|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> stroke |
| <input type="checkbox"/> disk problems | <input type="checkbox"/> cancer | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> decreased range of motion | <input type="checkbox"/> allergies to oils or perfumes | <input type="checkbox"/> arthritis, bursitis or gout |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> surgery | <input type="checkbox"/> HIV |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> breast augmentation | <input type="checkbox"/> broken bones |
| <input type="checkbox"/> any other infectious disease | | |

PLEASE INDICATE IF YOUR CONSUMPTION IS:

	None	Light	Moderate	Heavy
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE INDICATE THE PLACES YOU ARE FEELING DISCOMFORT:



DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- v I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- v I am responsible for paying for any appointment cancellation of less than 24 hours.
- v If you are late for an appointment, treatment time will be extended if at all possible; if times does not allow, you will be charged for the full session.

DATE: _____

SIGNATURE: _____
PLEASE ADVISE IF YOU ARE ILL — WE MAY NEED TO RESCHEDULE.